

STATE OF MARYLAND Reimbursement Claim Form - 24012

Part I: Employee Information (Please print or click in each box to enter your information.)

Employee Name (Last/First/MI)		Social Security Number (123456789)	
Employee e-mail Address-Completion of e-mail address will auto-enroll you to receive account e-mail correspondence.		Daytime Telephone Number	
Change of Address Submission – Please check box and complete the information below for address changes only. Note: The address change is only temporary; you must contact your employer for a permanent change of address.			
Employee Address		City	
Employee Address (e.g., Apt #, P.O. Box)		State	Postal Code

Part II: Health Care Reimbursement Request

Types of Service <small>Combine all same Type of Service Expenses</small>	Plan Type <small>HMO/DMO/POS Indemnity or Traditional</small>	Dates of Service <small>Date Format: MMDDYYYY</small>		Covered by Insurance <small>(Y/N)</small>	Explanation of Benefits (EOB) Included (Y/N)	Total Requested Amount
		Beginning Date	Ending Date			
Medical						
Vision						
Prescription						
Dental						
Orthodontics						
Other						
Total Requested Amount:						

Part III: Dependent Day Care Affidavit and Reimbursement Request

#	Dependent's Full Name	Date of Birth	Dates of Service		Total Requested Amount
			Beginning Date	Ending Date	
1					
2					
3					
Total Requested Amount:					

Provider Tax ID: _____ **Provider Name:** _____

I provided Adult/Child Day Care Services to the above individuals in accordance with the amounts and dates that are requested: (Only needed if you do not have supporting documentation)

Provider Signature: _____ **Date:** _____

TO EXPEDITE CLAIM PAYMENT, PLEASE COMPLETE AND FAX FORM TO: 866-643-2219 (TOLL FREE)

Part IV: Employee Certification for Reimbursement

I hereby certify that:

- The above information is correct;
- I have not received reimbursement previously for these expenses from my Flexible Spending Account(s) or any other plan and will not seek reimbursement by any other plan; and
- The total of any reimbursed dependent day care expenses does not exceed my or my spouse's earned income (W-2 Pay) for the year, if less than \$5,000.

I understand that:

- Reimbursement is not a guarantee that this payment is tax free;
- Reimbursement of dependent day care expenses will reduce and may eliminate completely my ability to claim a dependent day care credit on my personal income tax return;
- Dependent day care expenses reimbursed through this account cannot be used as a dependent day care credit on my personal tax return; and
- Health care expenses reimbursed through this account cannot be used as a deduction on my personal income tax return.

I hereby authorize release of payment through my Flexible Spending Account(s).
 I hereby authorize SHPS, Inc. or its representatives to obtain necessary information from all physicians, hospitals, medical service providers, dependent day care providers, pharmacists, employers, and all other agencies or organizations (this includes other insurers) to consider the claim for reimbursement under my Flexible Spending Account(s).

Employee Signature: _____ **Date:** _____

Reimbursement Request Form Instructions

Claim Submission:

Fax Submission – To expedite your claim payment, fax the completed and signed reimbursement claim form, along with all documentation, to the number listed above. Please send only one claim per transmission. Faxing multiple claim forms with documentation in one transmission will impact the processing of your reimbursement. Please do not include this instruction page with your fax.

Mail Submission – Please mail the completed and signed reimbursement claim form, along with all documentation, to SHPS FSA Administration at the address listed above.

Fill out the claim form completely and correctly to expedite your claim payment.

Your reimbursement can be sent electronically directly to your banking establishment or mailed to the address of record. You can sign up to receive your reimbursements directly to your bank account via electronic payment, view account history, or learn about our services by accessing mySHPS online services at www.shps.net.

Employee Instructions - Please read these instructions before completing the information requested on the claim form.

1. Complete all areas of Part I, "Employee Information."
Where applicable, complete Part II, "Health Care Expenses" and/or Part III "Dependent Day Care Expenses."
2. All health care expenses should first be filed under your employer's health care plan or any other coverage you may have before you request reimbursement from your Flexible Spending Account.
3. This form is to be used only to request reimbursement for:

Health Care Expenses

- Allowable expenses covered, but not fully reimbursed by any benefit plans. Attach a copy of the plan's Explanation of Benefits statement (EOB) as documentation.
- Allowable expenses **not** covered by any benefit plans. Attach bills or receipts that indicate the name and address of the provider of service. Please note on the form if the expenses are not covered by a health or dental plan.

Supporting Documentation - Health Care Expenses

In addition to the completion of the claim form, the documentation described under either A or B below must be attached.

A. Explanation of Benefits statement (EOB): This is the statement you receive each time you, or a health care provider, submit medical, dental or vision claims for payment to your health, dental or vision care plan. The EOB will show the amount of expenses paid by the plan and the amount you must pay. For expenses that are partially covered by your (or your dependent's) medical, dental or vision plans, you must attach the EOB. If you are covered under a HMO/DMO indicate "Co-pay" on Part II under "Type(s) of Service."

B. All Other Expenses: For expenses not covered at all by your (or your dependent's) medical, dental or vision plans, reimbursement requests will not be processed without acceptable evidence of your expenses. A cancelled check is not considered acceptable evidence. Acceptable evidence includes receipts, which contain the following information:

- Type of service or product provided
- Date expense was incurred
- Name of employee or dependent for whom the service/product was provided
- Person or organization providing the service/product
- Amount of expense

Dependent Day Care Expenses

In general, and subject to the rules of the dependent care plan sponsored by your employer, the following rules apply to dependent care expenses:

- The individual receiving care must be either a qualifying child or a qualifying relative;*
- The individual must be under the age of 13 unless he or she is physically or mentally unable to care for himself or herself.
- The expenses must be incurred so that you and your spouse, if married, can work or your spouse can attend school on a full-time basis.
- Child care or elder care centers must comply with all applicable state and local laws in order for dependent care expenses to be reimbursed from your Dependent Care Reimbursement Account.
- The annual amount of dependent day care claims cannot exceed your annual deposit amount up to (a) \$5,000, (b) \$2,500 if married and filing separate returns, or (c) your or your spouse's annual salary, if less than \$5,000.

NOTE: A recent change to the Internal Revenue Code revised the definition of "dependent." Generally speaking, a qualifying child must reside with you for more than half the year and must not provide over half of his/her own support. A qualifying relative is an eligible individual if (1) you provide more than half of the individual's support, (2) the individual's gross income is less than \$3,200 in 2005, and (3) the individual is not a qualifying child of you or any other taxpayer. **Please note that any questions regarding the status of an individual as either a qualifying child or a qualifying relative must be discussed with a qualified tax advisor in conjunction with the provisions of your employer's Dependent Care Reimbursement Plan.**

Supporting Documentation - Dependent Day Care Expenses

- For allowable Dependent Day Care expenses, attach a copy of the bill or signed receipt, or have the provider complete Part III, "Dependent Day Care Affidavit and Reimbursement Request" on the reverse side.
- Requests **will not be processed** without the Tax ID number for all providers.

4. Read the Employee Certification for Reimbursement statement, then sign and date the form where indicated.